Authorization to Release Information

I authorize my Physician to release information related to my request to Student Life for the purpose of obtaining exemption/reduction from my required meal plan and to discuss this request with a representative from Student Life, if necessary.

_____ _____

Student Signature Date

Exemptions to the meal plan requirements are granted only when the food service program is unable to meet the prescribed needs of the student. No exemption request will be considered without a completed Physician Advisor Statement.

To Be Completed by Licensed Medical Professional

_____

_____

Special Dietary Needs:_____

_____

_____

_____

I recommend the student be **EXEMPT** or allowed to purchase a **REDUCED** meal plan. *(Circle one)*

_____ _____

Physician Signature (Printed Name) Date

_____ _____

Address City, State, Zip

_____

Phone Number

Student Life Office Use Only

Date Received: ____/____/_____ □ Approved □ Denied Approval Signature:_____

Effective Date: ____/____/____ Documentation Attached: Y N

_____

Notification Sent to Student's USF Email Account? Y N Date Email Sent: ____/____/_____